

2012 AlohaCare Advantage (HMO) and AlohaCare Advantage Plus (HMO SNP) Drugs with Prior Authorization

You may need prior authorization for certain drugs that are on the formulary or drugs that are not on the formulary. Below is a drug that requires prior authorization with the prior authorization requirements.

AMITIZA

Drugs

Amitiza

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IN PATIENTS WITH CHRONIC IDIOPATHIC CONSTIPATION DEFINED ON AVERAGE AS LESS THAN 3 SEVERE BOWEL MOVEMENTS PER WEEK WITH ONE OR MORE OF THE FOLLOWING 1 VERY HARD STOOLS FOR AT LEAST QUARTER OF ALL BOWEL MOVEMENTS, 2 SENSATION OF INCOMPLETE EVALUATION FOLLOWING AT LEAST A QUARTER OF ALL BOWEL MOVEMENT, AND 3 STRAINING WITH DEFECATION AT LEAST A QUARTER OF THE TIME

Exclusion Criteria

DOES NOT MEET COVERED USE, DOES NOT HAVE DOCUMENTED FAILURE TO AT LEAST TWO OF THE FOLLOWING, FIBER, ANTISPASMODICS, LATULOSE, EXERCISE, OR FLUIDS, OR CONTRADICTIONS TO THE USE OF LUBIPROSTONE SUCH AS HISTORY OF MECHANICAL GASTROINTESTINAL OBSTRUCTION, CONSTIPATION CAUSED BY USE OF OTHER MEDICATIONS, KNOWN HYPERSENSITIVITY TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE, AND GASTROENTEROLOGIST ASSESSMENT RULING OUT MECHANICAL OBSTRUCTION

Age Restriction

FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

Prescriber Restriction

GASTROENTEROLOGIST EVALUATION REQUIRED

Coverage Duration

UP TO 12 MONTHS

Other Criteria

CHANTIX

Drugs

Chantix, Chantix Starting Month Pak

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D AND TRIED AND FAILED BUPROPION AND PATIENT MUST BE ENROLLED IN A BEHAVIORAL SUPPORT OR MODIFICATION PROGRAM AND PATIENT MUST BE MOTIVATED TO STOP SMOKING

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS OR MORE THAN ONE NICOTINE REPLACEMENT PRODUCT IS BEING USED SIMULTANEOUSLY OR PREGNANCY UNLESS THE BENEFIT OUTWEIGHS THE RISKS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE SUCH AS NAME OF PRIOR DRUGS FAILED AND DOCUMENTATION OF PROGRAM ATTENDED AND PATIENT MOTIVATION TO STOP SMOKING DOCUMENTED

Age Restriction

FOR PATIENTS 18 YEARS OF AGE OR OLDER ONLY

Prescriber Restriction

N/A

Coverage Duration

TWO TREATMENT CYCLES PER BENEFIT YEAR

Other Criteria

SPECIAL CONSIDERATIONS-PREGNANCY CATEGORY C, SAFETY AND EFFICACY IN CHILDREN AND ADOLESCENTS LESS THAN 18 YEARS OF AGE HAS NOT BEEN ESTABLISHED, CAUTION IN PATIENTS WITH RENAL DISEASE, IMPAIRMENT OR FAILURE

FORTEO

Drugs

Forteo

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D AND FAILED TWO PART D DRUGS USED TO TREAT OSTEOPOROSIS

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE AND BONE SCAN RESULTS UPON INITIAL REQUEST IF PATIENT IS GREATER THAN 74 YEARS OF AGE FOR OSTEOPOROSIS OR OSTEOPENIA

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS, NO GREATER THAN 24 MONTHS

Other Criteria

N/A

LIPITOR

Drugs

Lipitor

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR DOES NOT HAVE DOCUMENTED TREATMENT FAILURE ON SIMVASTATIN 80MG WITHIN THE LAST 180 DAYS OR HAS KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE SUCH AS NAMES OF PRIOR DRUGS FAILED

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

LUNESTA

Drugs

Lunesta

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IN PATIENTS WITH CLINICALLY DIAGNOSED INSOMNIA

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS OR HAVE NOT FAILED TRIALS ON TWO GENERIC SLEEP AGENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE SUCH AS NAMES OF PRIOR DRUGS FAILED

Age Restriction

FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-PREGNANCY CATEGORY C, ELDERLY PATIENTS MAY BE AT RISK FOR FALLS OR MENTAL STATUS CHANGES, NO DOSE ADJUSTMENT NECESSARY FOR PATIENTS WITH MILD-TO-MODERATE HEPATIC IMPAIRMENT, CAUTION IN PATIENTS WITH DEPRESSION SYMPTOMS, DOSE SHOULD BE REDUCED IN ELDERLY PATIENTS

Part B/D Drugs

Drugs

0.45 % NaCl-potassium chloride, Abelcet, Adagen, Adriamycin PFS, A-Hydrocort, albuterol sulfate, Aldurazyme, Alimta, Alkeran, allopurinol sodium, Aloprim, Aloxi, AmBisome, A-Methapred, Amevive, Aminosyn 10 %, Aminosyn 3.5 %, Aminosyn 5 % (sulfite-free), Aminosyn 7 %, Aminosyn 8.5 %, Aminosyn II 10 %, Aminosyn II 3.5 %/Dextrose 5 %, Aminosyn II 3.5 %-Dextrose 25%, Aminosyn II 3.5% M/Dextrose 5%, Aminosyn II 3.5%-Lytes-Ca-D25W, Aminosyn II 4.25%/Dextrose 20%, Aminosyn II 4.25%-Dextrose 10%, Aminosyn II 4.25%-Lytes-Ca-D25, Aminosyn II 5%/Dextrose 25%, Aminosyn II 7 %, Aminosyn II 8.5 %, Aminosyn M 3.5 %, Aminosyn-HBC 7%, Aminosyn-HF 8 %, Aminosyn-PF 10 %, Aminosyn-PF 7 % (Sulfite-Free), ammonium chloride, Amphotec, amphotericin b, Anzemet, APOKYN, Aralast NP, Aranesp (polysorbate), Arcalyst, Arixtra, Arranon, Atgam, AVASTIN, Avelox in NaCl (iso-osmotic), Avonex, Avonex Administration Pack, Azasan, azathioprine, azathioprine sodium, Bentyl, Betaseron, BiCNU, bleomycin, Boniva, Brovana, bumetanide, buprenorphine, Busulfex, Campath, Cancidas, Capastat, carboplatin, Carimune NF Nanofiltered, Carnitor, cefuroxime sodium, CellCept, CellCept Intravenous, Ceredase, Cerezyme, Cesamet, chloramphenicol sod succinate, chlorothiazide sodium, cisplatin, cladribine, Claforan, Cleocin in D5W, Clinimix 2.75%/D5 Sulfite Free, Clinimix 4.25%/D5 Sulfite Free, Clinimix 4.25/D10 Sulfite Free, Clinimix 4.25/D20 Sulfite Free, Clinimix 5%/D15 Sulfite Free, Clinimix 5%/D20 Sulfite Free, Clinimix 5%/D25 Sulfite Free, Clinimix E 2.75/D10 SulfiteFree, Clinimix E 2.75/D5 SulfiteFree, Clinimix E 4.25/D25 SulfiteFree, Clinimix E 4.25/D5 SulfiteFree, Clinimix E 5%/D15 Sulfite Free, Clinimix E 5%/D20 Sulfite Free, Clinimix E 5%/D25 Sulfite Free, CLOLAR, Copaxone, Cosmegen, cromolyn, CUBICIN, cyclophosphamide, cyclosporine, cyclosporine modified, cytarabine, cytarabine (PF), Cytovene, D10 %-0.45 % sodium chloride, D10-0.2 % NaCl & Potassium Cl, D2.5 %-0.45 % sodium chloride, D5 %-0.45 % sodium chloride, D5 %-0.9 % sodium chloride, D5-1/2 NS & potassium chloride, D5-1/3 NS & potassium chloride, D5-1/4 NS & potassium chloride, D5-NS with potassium chloride, D5W with potassium chloride, dacarbazine, Dacogen, daunorubicin, DaunoXome, DECAVAC, Depo-Provera, Depo-SubQ provera 104, desmopressin, dexrazoxane, dextrose 10% in water (D10W), dextrose 10%-1/4 normal saline, dextrose 5% in water (D5W), dextrose 5%-0.3 % sod.chloride, dextrose 5%-1/4 normal saline, dicyclomine, Diuril IV, docetaxel, Doribax, Doxil, doxorubicin, dronabinol, ELAPRASE, electrolyte-48 in D5W, Eligard, Elitek, Ellence, Eloxatin, Elspar, Emend, Enbrel, Engerix-B (PF), enoxaparin, epirubicin, Epogen, Eraxis(Water Diluent), Erbitux, Erythrocin, Etopophos, etoposide, Fabrazyme, Faslodex, fentanyl citrate (PF), fluconazole in dextrose(iso-o), fludarabine, fluorouracil, Fragmin, Freamine III 3 %-Electrolytes, Freamine III 8.5 %, GamaSTAN S/D, Gammagard Liquid, Gamunex, ganciclovir sodium, Gemzar, Gengraf, Genotropin, Genotropin Miniquick, gentamicin in NaCl (iso-osm), Geodon, granisetron, granisetron (PF), Granisol, Halaven, Havrix (PF), Hectorol, heparin (porcine) in D5W, Hepatamine 8%, Hepatasol 8 %, Herceptin, Humatrope, Humira, Hycamtin, idarubicin, Ifex, ifosfamide, ifosfamide-mesna, Imovax Rabies Vaccine, Increlex, Infergen, Infumorph P/F, Innohep, Intralipid, Intron A, Invanz, Invega Sustenna, Ionosol-B in D5W, Ionosol-MB in D5W, Ionosol-T in D5W, Isolyte-H in D5W, Isolyte-P in D5W, Isolyte-S, Isolyte-S in D5W, Ixempra, Kepivance, Keppra, Kineret, lactated ringers, Lanoxin Pediatric, leucovorin calcium, Leukine, leuprolide, Leustatin, Levaquin, Levaquin in D5W, levetiracetam, levocarnitine, Lovenox, Lupron Depot, Lupron Depot (3 Month), Lupron Depot (4 Month), Lupron Depot-Ped, magnesium sulfate, medroxyprogesterone, melphalan, meropenem, Merrem, mesna, methotrexate sodium, methotrexate sodium (PF), methylprednisolone acetate, methylprednisolone sodium succ, metoclopramide, metoprolol tartrate, mitomycin, mitoxantrone, Mustargen, Mycamine, mycophenolate mofetil, Myfortic, Myozyme, Naglazyme,

Nebupent, Neoral, Nephramine 5.4 %, Neulasta, Neumega, Neupogen, Norditropin FlexPro, Norditropin Nordiflex, Normosol-R in D5W, Normosol-R pH 7.4, NS with potassium chloride, Nutropin, Nutropin AQ, Nutropin AQ Nuspin, octreotide acetate, Omnitrope, ondansetron, ondansetron HCl, ondansetron HCl (PF), Ontak, Orenicia, Orthoclone OKT3, oxacillin in dextrose, iso-osm, oxaliplatin, paclitaxel, PegIntron, PegIntron Redipen, penicillin G pot in dextrose, penicillin G procaine, penicillin G sodium, Pentam, pentostatin, Perforomist, Photofrin, piperacillin, piperacillin-tazobactam, Plasma-Lyte 148, Plasma-Lyte 148 in D5W, Plasma-Lyte 56, Plasma-Lyte A, Plasma-Lyte R, Plasma-Lyte-56 in D5W, potassium chloride, Prednisone Intensol, Premarin, Premasol 10 %, Premasol 6 %, Procalamine 3%, Procrit, Prograf, Prolastin, Prolastin C, Proleukin, Prosol 20%, Pulmicort, Pulmozyme, RabAvert (PF), Rapamune, Rebif, Recombivax HB (PF), Remicade, Remodulin, Rheumatrex, Risperdal Consta, Rituxan, Robaxin, Saizen, Saizen click.easy, Sandimmune, Serostim, Simulect, sodium chloride, sodium chloride 0.45 %, sodium chloride 0.9 %, sodium chloride 3 %, sodium chloride 5 %, Sodium Edecrin, sodium lactate, Solu-Cortef (PF), Solu-Medrol, Solu-Medrol (PF), Somatuline Depot, SOMAVERT, streptomycin, Synercid, tacrolimus, Talwin, Taxotere, terbutaline, tetanus toxoid, adsorbed (PF), tetanus, diphtheria toxoid ped-PF, tetanus-diphtheria toxoids-Td, Tev-Tropin, thiotepa, Thymoglobulin, Timentin, Tobi, tobramycin in NS, topotecan, Torisel, toremide, Treanda, Trelstar, Trexall, Trisenox, TrophAmine 10 %, Trophamine 6%, Twinrix (PF), Tygacil, TYSABRI, Uvadex, vancomycin, Vagta (PF), Vectibix, VELCADE, Ventavis, Vfend IV, Vidaza, vinblastine, vincristine, vinorelbine, Vistide, Vivaglobin, Vivitrol, Xgeva, Xolair, Zanosar, Zemaira, Zemplar, Zinacef in Sterile Water, Zinecard, Zometa, Zorbitive, Zortress, Zosyn, Zosyn in dextrose (iso-osm)

Covered Uses

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

N/A

Other Criteria

N/A

RANEXA

Drugs

Ranexa

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D AND RESERVED FOR PATIENTS WITH CHRONIC STABLE ANGINA

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR DOES NOT HAVE DOCUMENTED FAILURE OF ALTERNATIVE FORMULARY ANTIANGINAL AGENT, BETA-BLOCKER, CALCIUM CHANNEL BLOCKER, OR INITRATE, OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE

Age Restriction

N/A

Prescriber Restriction

MUST BE PRESCRIBED BY A CARDIOLOGIST

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-RANEXA DOES NOT POSSESS NEGATIVE CHRONOTROPIC OR INOTROPIC EFFECTS AND HAS HAD MINIMAL EFFECTS ON HEART RATE AND BLOOD PRESSURE

ROZEREM

Drugs

Rozerem

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IN PATIENTS WITH CLINICALLY DIAGNOSED INSOMNIA, AGE 18 AND ABOVE, AND FAILED OR INTOLERANT TO TWO GENERIC SLEEP AGENTS

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE, CONFIRMED INSOMNIA DIAGNOSIS, AND DRUG NAMES OF TWO GENERIC SLEEP AGENTS FAILED OR INTOLERANT

Age Restriction

FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-PREGNANCY CATEGORY C, HAS NOT BEEN STUDIED AND IS NOT RECOMMENDED IN PATIENTS WITH SEVERE COPD AND SEVERE OSA, DOES NOT EXACERBATED MILD TO MODERATE OSA, SHOULD NOT BE USED IN PATIENTS WITH SEVERE HEPATIC IMPAIRMENT AND CAUTION IN MODERATE IMPAIRMENT, CAUTION IN PATIENTS WITH DEPRESSION SYMPTOMS

SMOKING DETERRENTS

Drugs

Nicotrol, Nicotrol NS

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D AND ENROLLMENT IN A BEHAVIORAL SUPPORT OR MODIFICATION PROGRAM AND DOCUMENTED SUCCESS IN SMOKING CESSATION

Exclusion Criteria

DOES NOT MEET COVERED USE OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS OR SIMULTANEOUS USE OF MORE THAN ONE NICOTINE REPLACEMENT PRODUCT OR CONCURRENT ZYBAN OR MAO INHIBITOR DRUG OR PRESENCE OF A EATING DISORDER SUCH AS ANOREXIA, BULIMIA OR PRESENCE OF A SEIZURE DISORDER

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE AND DOCUMENTATION OF PROGRAM ATTENDED AND SUCCESS WITH USE

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

TWO TREATMENT CYCLES PER BENEFIT YEAR

Other Criteria

N/A

SYMLIN

Drugs

Symlin, SymlinPen 120, SymlinPen 60

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IN TYPE 1 DIABETIC PATIENTS WHO HAVE FAILED TO ACHIEVE ADEQUATE GLYCEMIC CONTROL DESPITE INSULIN THERAPY OR TYPE 2 DIABETIC PATIENTS WHO HAVE FAILED TO ACHIEVE ADEQUATE GLYCEMIC CONTROL DESPITE INSULIN THERAPY IN COMBINATION WITH SULFONYLUREAS AND/OR METFORMIN AND GLYCOSYLATED HEMOGLOBIN LESS THAN OR EQUAL TO 9 PERCENT

Exclusion Criteria

DOES NOT MEET COVERED USE OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS OR PATIENT HAS RECURRENT EPISODES OF SEVERE HYPOGLYCEMIA REQUIRING ASSISTANCE WITHIN THE PAST 6 MONTHS OR PATIENT REQUIRES DRUGS THAT STIMULATE GASTROINTESTINAL MOTILITY

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE SUCH AS NAMES OF PRIOR DRUGS FAILED AND MOST RECENT HGB A1C

Age Restriction

SHOULD NOT BE USED IN PEDIATRIC PATIENTS

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-CAUTION IN PATIENTS WITH A HISTORY OF POOR COMPLIANCE WITH CURRENT INSULIN REGIMEN, CAUTION IN PATIENTS WITH A HISTORY OF POOR COMPLIANCE WITH SELF-BLOOD GLUCOSE MONITORING, PREGNANCY CATEGORY C, FDA BLACK BOX WARNING REGARDING HYPOGLYCEMIA

TEKTURNA

Drugs

Tekturna, Tekturna HCT

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D AND FAILURE ON FORMULARY GENERIC ANTI-HYPERTENSIVES AND FAILURE ON FORMULARY ACE-INHIBITORS OR ARBS

Exclusion Criteria

DOES NOT MEET COVERED USE OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS OR PATIENT IS AN ADOLESCENT OR CHILD OR PATIENT HAS RENAL ARTERY STENOSIS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE SUCH AS NAMES OF PRIOR DRUGS FAILED

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-CAUTION IN PATIENTS WITH A HISTORY OF DIALYSIS, NEPHROTIC SYNDROME OR RENOVASCULAR HYPERTENSION, CAUTION IN PATIENTS WITH BILIARY CIRRHOSIS OR CHILD-PUGH CLASS B OR C

TRACLEER

Drugs

Tracleer

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-ENROLLMENT OF PATIENTS IN THE TRACLEER ACCESS PROGRAM IS REQUIRED AS TRACLEER CANNOT BE DISPENSED THROUGH TRADITIONAL RETAIL PHARMACIES. ENROLLMENT FORM MUST BE SIGNED BY BOTH THE PATIENT AND PHYSICIAN.

XOPENEX

Drugs

levalbuterol HCl, Xopenex

Covered Uses

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IN PATIENTS 6 YEARS OF AGE AND OLDER AND PATIENTS THAT HAVE A CONTRAINDICATION, ALLERGY, OR INTOLERANCE TO ALBUTEROL

Exclusion Criteria

DOES NOT MEET COVERED USE CRITERIA OR KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

Required Medical Information

MEDICAL RECORD NOTES SUPPORTING COVERED USE SUCH AS NAMES OF PRIOR DRUGS FAILED

Age Restriction

FOR PATIENTS 6 YEARS OF AGE AND OLDER ONLY

Prescriber Restriction

N/A

Coverage Duration

UP TO 12 MONTHS

Other Criteria

SPECIAL CONSIDERATIONS-SAFE AND EFFECTIVE USE OF THE NEBULIZER SOLUTION IN CHILDREN LESS THAN 6 YEARS HAS NOT BEEN ESTABLISHED, SAFE AND EFFECTIVE USE OF THE METERED-DOSE INHALER IN CHILDREN LESS THAN 4 YEARS HAS NOT BEEN ESTABLISHED, PREGNANCY CATEGORY C, CAUTION IN PATIENTS WITH CARDIOVASCULAR DISEASE, DIABETES, AND HYPERTHYROIDISM

If you have any questions about the prior authorization requirements, contact Customer Service at 973-6395 or toll free at 1-866-973-6395, 8 a.m. to 8 p.m., 7 days a week. TTY users call 1-877-447-5990.

*AlohaCare Advantage is a health plan with a Medicare contract. AlohaCare Advantage Plus is a Coordinated Care plan with a Medicare Advantage contract but **without** a contract with the Hawaii Medicaid program.*

Call 1-866-973-6395 to receive material in an alternate format or language.